

## CORRESPONDENCE

family practice training as legitimate in producing a competent physician. Because of this, medical students are given distorted myths and family practice residents are unnecessarily hassled. People everywhere seem to like having a good family doctor, and most of the towns in this country are too small to support any other type of physician. Apparently, physicians with three or more years of training in a single discipline cannot accept competence in a field with three years of training covering many disciplines. How many months or years of postgraduate training does it take to become competent in an area of medicine? Ironically, Dr. Kurtz feels that more than three years are necessary for competence with adult medical problems, while his residents in primary care internal medicine are likely to learn their gynecology and orthopedics in a few months.

Some academic internists have been very supportive of family practice and have greatly helped the discipline become established in medical education. An editorial by Perkoff eloquently describes this attitude.<sup>2</sup> As stated by Geyman<sup>3</sup> there will be several approaches to primary care in this country. Americans like variety and choices, and family physicians, pediatricians and internists all have their place on the front lines of medical practice. We should respect and help each other in meeting the public's needs, for if we do not I imagine that chiropractors and others will.

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## Incidence of *Campylobacter* Enterocolitis

TO THE EDITOR: I enjoyed Dr. Ginsberg's short review of gastrointestinal disease and infectious diarrhea<sup>1</sup> in the January issue. However, the discussion on *Campylobacter fetus* subspecies *jejuni*

does not emphasize the frequency of enterocolitis due to this organism. Recent data indicate that in numerous geographic areas *Campylobacter* is as common as *Salmonella* and *Shigella* combined.<sup>2,3</sup> Our experience in Marin County, northern California, suggests that *Campylobacter* enteritis is far more frequent than this. Two community hospitals are finding many more times *Campylobacter* versus *Shigella* and *Salmonella*. In 1981, there were 290 stool cultures processed from a 34-physician multispecialty group. Thirty-seven were positive for *Campylobacter jejuni*, one for *Shigella* and three for *Salmonella*. The cases involving *Salmonella* and *Shigella* occurred in the summer months and there was a clear epidemiological history. The cases involving *Campylobacter* were more evenly spread throughout the year, with increased frequency from September through to December. Most stool specimens positive for *Campylobacter* contained blood or polymorphonucleocytes, or both.

Frequent occurrence of disease due to *Campylobacter* in the winter months is an important issue for community clinicians. This bacterium should be considered as the most likely cause of acute diarrhea when the stool contains blood and pus. Whether erythromycin therapy should be started before culture results are obtained (often taking two to three days) has not been studied. The natural course of *Campylobacter* enteritis does not appear to be influenced by therapy started as late as four to six days after onset of symptoms.<sup>3</sup> Certainly our anecdotal experience suggests prompt resolution of the often debilitating symptoms when treatment has been started before the confirmation of *Campylobacter* enterocolitis by culture.

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